



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES
NUTRITION ASSESSMENT FOR WOMEN

PARTICIPANT NAME AND DCN	DATE OF BIRTH	CATEGORY P / B / N	DATE COMPLETED
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Form completed by: ☐ Participant or WIC Staff: ☐ CPA ☐ RD ☐ Nutritionist ☐ WIC Certifier

Please think about your usual eating pattern and answer the following questions to the best of your ability.
Place a check mark in the box ☒ and/or **write-in** your answer.

MEAL PATTERN (This section is to be completed for all Women)

1. How many times a day do you eat? _____ meals/day _____ snacks/day
What type foods do you typically snack on? Check all that apply.
☐ Milk, yogurt, cheese ☐ Meat, fish, eggs, beans ☐ Fruits or vegetables ☐ Other:
☐ Bread, cereal, rice and pasta ☐ Chips/salty foods ☐ Cookies/cakes/sugary foods

2. In a typical week, how many meals do you eat from a restaurant, including fast food? _____ meals/week

3. How many days a week does your family usually eat a meal together? _____ days/week ☐ Does not apply (single)

4. Is there anything you would like to change about the food you eat? ☐ Yes ☐ No
List changes:

EATING PATTERN (This section is to be completed for all Women)

5. How are most foods prepared? Check all that apply.
☐ Baked ☐ Fried ☐ Boiled ☐ Roasted ☐ Broiled ☐ Grilled ☐ Microwaved

6. Are there any foods that you think you don't eat enough of? ☐ Yes ☐ No
If yes, check all that apply.
☐ Milk, yogurt, cheese ☐ Meat, fish, eggs, beans ☐ Fruits ☐ Vegetables ☐ Bread, cereal, rice and pasta

*7. Are you following a special diet? [341-362 427.2] ☐ Yes ☐ No
If yes, check type.
☐ Vegetarian ☐ Vegan ☐ Low calorie/weight loss ☐ Macrobiotic ☐ Food allergy or intolerance
☐ Low Fat ☐ Low carbohydrate ☐ Other:

*8. Some women crave non-food items. Do you eat any of these items? [427.3] ☐ Yes ☐ No
If yes, check all that apply.
☐ Ashes ☐ Chalk ☐ Large quantities of ice and/or freezer frost ☐ Other:
☐ Baking Soda ☐ Cigarettes ☐ Paint Chips
☐ Burnt Matches ☐ Clay ☐ Soil
☐ Carpet fibers ☐ Dust ☐ Starch (laundry or cornstarch)

BEVERAGES (This section is to be completed for all Women)

9. Do you drink milk? ☐ Yes ☐ No
If yes, check type.
☐ Fat-free (skim) ☐ Low-fat (1%) ☐ Reduced fat (2%) ☐ Whole ☐ Rice Milk
☐ Soy Milk ☐ Powdered ☐ Evaporated ☐ Sweetened Condensed ☐ Goat's milk
☐ Other:

10. How often do you drink milk? Check one.
☐ Several times/day ☐ Once/day ☐ Less than once/day

11. How often do you eat other dairy foods such as cheese, yogurt, or pudding?
☐ Several times/day ☐ Once/day ☐ Less than once/day

12. What other beverages do you drink in a typical day? Check all that apply.
☐ Juice ☐ Water ☐ Fruit drinks ☐ Sports drinks ☐ Regular pop/soda ☐ Diet pop/soda ☐ Coffee/tea
☐ Beer ☐ Wine ☐ Other alcoholic drinks ☐ Other:

13. What is your main source of drinking water? Check one.
- ☐ City water system ☐ Rural water system ☐ Private well ☐ Bottled water
- a. If private well, has it been tested for bacteria or nitrates? ☐ Yes ☐ No ☐ Don't know
- If yes, check results: ☐ Safe ☐ Unsafe ☐ Don't know
- b. Do you know if your water is fluoridated? ☐ Yes ☐ No ☐ Don't know
- c. Do you brush your teeth with toothpaste that has fluoride? ☐ Yes ☐ No ☐ Don't know

SUPPLEMENTS (This section is to be completed for all Women)

14. Did you take a multivitamin in the month before your most recent pregnancy? [427.4] ☐ Yes ☐ No
- If yes, how many times a week? _____ times/week

15. Have you taken any vitamins, minerals, herbs or herbal supplements in the past month or currently? [427.1 427.4] ☐ Yes ☐ No
- If yes, check all that apply.
- ☐ Prenatal vitamin ☐ Multivitamin (not a prenatal) ☐ Iron Supplement ☐ Herbal Supplement
- ☐ Others:

16. Do you use iodized salt? ☐ Yes ☐ No

FOOD SAFETY (This section is to be completed for all Women)

17. Do you have adequate equipment for food storage and preparation such as a refrigerator, a stove that works, and storage free from pests and harmful chemicals? ☐ Yes ☐ No

FOOD SECURITY AND PROGRAM PARTICIPATION (This section is to be completed for all Women)

18. In the past month, did you or anyone in your household ever eat less than you felt you should or not eat for a whole day because there wasn't enough money for food? ☐ Yes ☐ No ☐ Don't know or refused

19. Are you participating in any food and nutrition program? ☐ Yes ☐ No
- If yes, check all that apply.
- ☐ Food Stamps ☐ School Lunch ☐ Family Nutrition Education Program (FNEP) ☐ Commodity Program
- ☐ Food Pantry ☐ Other:

PHYSICAL ACTIVITY (This section is to be completed for all Women)

20. In a typical day, how many **minutes** are you physically active? ☐ None ☐ 1-30 ☐ 31-60 ☐ More than 60

PREGNANCY (Complete this section only if you are currently pregnant)

21. How much weight do you think you should gain with this pregnancy? _____ Pounds ☐ No Idea

22. Are you having any of the following problems? ☐ Yes ☐ No
- If yes, check all that apply.
- ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Other:

***23. Do you eat foods such as: [427.5]**

- a. raw fish or shellfish ☐ Yes ☐ No
- b. refrigerated smoked seafood ☐ Yes ☐ No
- c. raw or undercooked meat, chicken or turkey ☐ Yes ☐ No
- d. uncooked luncheon meats, deli meats, hot dogs ☐ Yes ☐ No
- e. refrigerated pate or meat spreads ☐ Yes ☐ No
- f. unpasteurized milk or foods containing unpasteurized milk ☐ Yes ☐ No
- g. soft cheeses such as Feta, Brie, Camembert, blue-veined cheese, Mexican-style cheese ☐ Yes ☐ No
- h. raw or undercooked eggs or foods containing raw or lightly cooked eggs ☐ Yes ☐ No
- i. raw vegetable sprouts such as alfalfa, clover and radish ☐ Yes ☐ No
- j. unpasteurized fruit or vegetable juices ☐ Yes ☐ No

BREASTFEEDING (Complete this section only if you are currently breastfeeding)

24. Do you have any concerns related to breastfeeding? [602] ☐ Yes ☐ No
- If yes, list concerns:

TO BE COMPLETED BY WIC OFFICE PERSONNEL ONLY

SIGNATURE (RISK ASSESSMENT)

SIGNATURE (NUTRITION COUNSELING)

DATE

TITLE

DATE

TITLE